

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (121)

## CERTIFICATE OF DEATH

07275

Reg. Dist. No. 290

1. PLACE OF DEATH  
 County Talbot County  
 City or town Easton, Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 13 da.  
 Hospital, institution, or street address where death occurred:  
Memorial Hospital  
 How long in hospital or institution? 13

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State Maryland County Caroline  
 City or town Deaton  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION) ☒  
 2. (a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

## 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced married  
 6. (b) Name of husband or wife Mary Odine Brown  
 6. (c) If alive, give age 65 years  
 7. Birth date of deceased (mo., day, yr.) May 20, 1870  
 8. AGE: Years 75 Months 2 Days 10 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Delaware  
 (Town, county, and state)  
 10. Usual occupation Farmer  
 11. Industry or business \_\_\_\_\_  
 12. Name John Brown  
 13. Birthplace Del.  
 14. Maiden name Katherine Hawley  
 15. Birthplace Del.

16. Informant Mrs. John Brown  
 Address Deaton Ind.  
 17. Buried Date thereof 7-2-45  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematorium St. Mary's Cemetery  
 Location Harrington, Del.  
 18. Funeral director J. Siegel, Harrington, Del.  
 Address Deaton Ind.  
 19. 7/31 19 45 N.H. Nevers  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 7-30 19 45 at 1 A M  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 17 19 45 to July 30 19 45  
 and that I last saw him alive on July 30 19 45  
 Immediate cause of death \_\_\_\_\_

Other conditions Septicemia, arteriosclerosis, chronic nephritis  
 (Include pregnancy within 3 months of death)  
 Major findings of operations Perforated appendix  
 Date of op. 7/28/45  
 Autopsy results \_\_\_\_\_  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_  
 23. SIGNATURE McPalmer M. D. or other \_\_\_\_\_  
Easton Ind. Address \_\_\_\_\_ Date signed 7/31

RECEIVED

AUG 7 1945

BUREAU V. B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

07276

Reg. Dist. No. 294

1. PLACE OF DEATH: *Talbot*  
 County.....  
 City or town.....  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?.....  
 Hospital, institution, or street address where death occurred:  
 .....  
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State..... County.....  
 City or town.....  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.....  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

3. (a) FULL NAME

3. (b) Social Security Number

4. Sex *Male* 5. Color or race *Col* 6. (a) Single, married, widowed, or divorced *Married*  
 6. (b) Name of husband or wife.....  
 7. Birth date of deceased (mo., day, yr.) *2-24-1867* 6. (c) If alive, give age..... years  
 8. AGE: Years *78* Months *4* Days *6* If less than one day..... hrs. .... min.

9. Birthplace.....  
 (Town, county, and state)  
 10. Usual occupation.....  
 11. Industry or business.....  
 12. Name.....  
 13. Birthplace.....  
 14. Maiden name.....  
 15. Birthplace.....

16. Informant.....  
 Address.....  
 17. *Burial* Date thereof.....  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory.....  
 Location.....  
 18. Funeral director.....  
 Address.....  
 19. *7-20* 19 *45*  
 (Date rec'd by registrar) Anna Carey Thomas Registrar

MEDICAL CERTIFICATION  
July 18, 194520. DATE OF DEATH..... 19..... at *12:05* a.m.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *a.m.*

March 15, 1945..... 19..... to July 18, 1945

and that I last saw him alive on July 14, 1945

Immediate cause of death *acute uremia**hypertension*Due to *arteriosclerotic nephritis*

Due to.....

Other conditions.....

Generalized *arteriosclerosis*  
 (Include pregnancy within 3 months of death)

Major findings of operations..... None

None Date of op. None

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....  
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work.....

23. SIGNATURE.....

St. Michaels, Md

Address..... Date signed.....

DURATION  
Several yrs.

RECEIVED  
JUL 25 1945  
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 830

## CERTIFICATE OF DEATH



Reg. Dist. No. 290

## 1. PLACE OF DEATH:

County Talbot  
 City or town Easton P.R.#2  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 30 Yrs.  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Talbot  
 City or town Easton  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. P.R.#2  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

VIRGINIA COURSEY (NEE COLEMAN)

## 3. (b) Social Security Number

✓

4. Sex Female 5. Color or race Caucas 6.(a) Single, married, widowed, or divorced Married  
 6.(b) Name of husband or wife Banks Coursey  
 6.(c) If alive, give age 68 years  
 7. Birth date of deceased (mo., day, yr.) Unknown  
 8. AGE: 50 Years Months Days If less than one day  
 .hrs. .min.

9. Birthplace Talbot Co. Md.  
 (Town, county, and state)  
 10. Usual occupation Domestic  
 11. Industry or business  
 12. Name Fletcher  
 13. Birthplace Talbot Co. Md.  
 14. Maiden name Unknown  
 15. Birthplace

16. Informant Banks Coursey (Husband)  
 Address Easton, Md. P.R.#2  
 17. Burial Date thereof July 14, 1945  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory New Chapel  
 Location Easton, Md. (Rural)  
 18. Funeral director J. Ellis Clark  
 Address Easton, Md.  
 19. 2112 19 45 N.D. Neerues  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 11 19 45, at 2 P. M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 11 19 45 to July 11 19 45; and that I last saw him alive on July 11 19 45.  
 Immediate cause of death Cerebral Hemorrhage 1 day  
 Due to Hypertension  
 Due to  
 Other conditions  
 (Include pregnancy within 3 months of death)

Major findings of operations  
 Date of op.  
 Autopsy results  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.  
 22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide Date of  
 Where did injury occur? (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Means of injury Injured at work?  
 23. SIGNATURE Haynes J. Clark, M.D.  
 Address Easton, Md. Date signed 7/13/45

RECEIVED  
JUL 16 1948  
BUREAU V. R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Addition of alternate name  
according to statement of **MARYLAND STATE DEPARTMENT OF HEALTH**  
Roy Culver, brother of deceased. 2411 N. Charles St., Baltimore 754  
Film G97, Aug. 31, 1945 YHL

# CERTIFICATE OF DEATH

07278

Reg. Dist. No. 290

## 1. PLACE OF DEATH:

County Talbot County  
City or town Easton, Md.  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 1 da.  
Hospital, institution, or street address where death occurred:  
Memorial Hospital  
How long in hospital or institution? 1 da.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Caroline Co.  
City or town Federalburg, Md.  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. \_\_\_\_\_  
(If rural, give LOCATION) ✓  
2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Albert Cover (ALBERT ELLWOOD CULVER)

## 3. (b) Social Security Number

217-09-6922

4. Sex Male 5. Color or race Black 6.(a) Single, married, widowed, or divorced Single  
6.(b) Name of husband or wife \_\_\_\_\_  
7. Birth date of deceased (mo., day, yr.) March 15, 1906  
8. AGE: Years 39 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Anne Arundel Co. Md.  
(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business Factory

12. Name Daniel Cover (Culver)

13. Birthplace Anne Arundel Co. Md.

14. Maiden name Louise Smith

15. Birthplace Anne Arundel Co. Md.

16. Informant Nora Peterson

Address Federalburg, Md.

17. Burial Date thereof Aug 1, 1945  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory \_\_\_\_\_

Location Baltimore Md.

18. Funeral director J. F. Frampton & Son

Address Federalburg, Maryland

19. 7/30 45 N. H. Meines  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 29 1945, at 9:30 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 28 1945 to July 29 1945  
and that I last saw him alive on July 29 1945

Immediate cause of death Myocardial infarction

DURATION 2 da.

Due to Chronic myocarditis

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE J. L. Brown M.D.  
Address Federalburg, Md. Date signed 7/30/45



RECEIVED  
AUG 4 1945  
BUREAU V.S.



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 50

## CERTIFICATE OF DEATH

07279

★ Reg. Diat. No. 290

1. PLACE OF DEATH:  
County Talbot  
City or town Easton, Md.  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 7 Months  
Hospital, institution, or street address where death occurred:  
309 Brookletts Ave.  
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State Maryland County Talbot  
City or town Easton  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 309 Brookletts Ave.  
(If rural, give LOCATION)  
2. (a) If veteran, name war

3. (a) FULL NAME

MAGGIE ELLIOTT

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed  
6. (b) Name of husband or wife William H. Elliott  
7. Birth date of deceased (mo., day, yr.) March 6, 1875 6. (c) If alive, give age \_\_\_\_\_ years  
8. AGE: Years 70 Months 4 Days 10 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Talbot Co. Md.  
(Town, county, and state)

10. Usual occupation Domestic

11. Industry or business

FATHER 12. Name Ezekiel Cooper

13. Birthplace Maryland

MOTHER 14. Maiden name Louisa Smith

15. Birthplace Maryland

16. Informant Lena Elliott

Address Easton, Md.

17. Burial Date thereof July 18, 1945  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Spring Hill

Location Easton, Md.

18. Funeral director J. Ellis Clark

Address Easton, Md.

19. 7/17 19 45 N.Y. Hurin  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH July 16 19 45 at 7:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 12 19 44 to July 16 19 45

and that I last saw him alive on July 16 19 45

Immediate cause of death Carcinoma of heart DURATION 4 yrs.

Due to

Due to

Other conditions Metastases to Brain + Liver 2 mos.

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: no

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE D. W. P. Stearns M.D. M. D. or other

Address Easton Md Date signed 7-17-45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
JUL 20 1945  
BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 942

07280

## CERTIFICATE OF DEATH

★ Reg. Dist. No. 290

## 1. PLACE OF DEATH:

County Tell County  
 City or town Easton, Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 14 days  
 Hospital, institution, or street address where death occurred:  
Memorial Hospital, Easton  
 How long in hospital or institution? 14 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Caroline  
 City or town Federalburg  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION) ✓  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Ira F. Fleebarty

## 3. (b) Social Security Number

215-20-1767

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced married  
 6. (b) Name of husband or wife Annie J. Fleebarty  
 6. (c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) April 13, 1881  
 8. AGE: Years 64? Months 3 Days 16 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Caroline Co. Md.  
 (Town, county, and state)

10. Usual occupation Laborer

11. Industry or business Factory

12. Name Charles F. Fleebarty

13. Birthplace Caroline Co. Md.

14. Maiden name Ida Turner

15. Birthplace Caroline Co. Md.

16. Informant Mrs. Lewis Lord

Address Preston Md. R1

17. Burial Date thereof 8/2/45  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Friendship

Location Near Federalburg Md.

18. Funeral director J. J. Trappington Son

Address Federalburg Md.

19. 7/30 19 45 R.A. Norris  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 7-29 19 45 at 4:10 A.M. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 16 19 45 to July 29 19 45

and that I last saw him alive on July 29 19 45

Immediate cause of death Acute Cardiac failure

Due to Coronary heart block

Due to Chadwick's Stasis

Other conditions Coronary thrombosis

Other conditions Cerebral congestion

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE J. J. Trappington (M.D.)

Address Easton Md. M. D. or other 7/30/45

Date signed \_\_\_\_\_

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
AUG 4 1945  
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 832

## CERTIFICATE OF DEATH

07281



Reg. Dist. No. 290

## 1. PLACE OF DEATH:

County TalbotCity or town Easton, Md.  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 2 hrs.

Hospital, institution, or street address where death occurred

Easton Memorial HospitalHow long in hospital or institution? 2 hrs.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For new born infants give residence of mother)

State Maryland County TalbotCity or town Williamstown  
(If outside city or town limits, write RURAL and give nearest town)Street No. (Rural)  
(If rural, give LOCATION)2. (a) If veteran, name war WORLD WAR #1

## 3. (a) FULL NAME

MAT C. GREEN

## 3. (b) Social Security Number

214-12-5624

## 4. Sex

Male

## 5. Color or race

Caucasoid

## 6. (a) Single, married, widowed, or divorced

Widowed

## 6. (b) Name of husband or wife

Rena Hardin

## 7. Birth date of deceased (mo., day, yr.)

Unknown

## 6. (c) If alive, give age ..... years

## 8. AGE:

Years

Months

Days

If less than one day

unk.

hrs.

min.

## 9. Birthplace

Williamstown, Talbot Co. Md.  
(Town, county, and state)

## 10. Usual occupation

Farming

## 11. Industry or business

## MOTHER

## 12. Name

Unknown

## 13. Birthplace

Emily Matilda Green

## 14. Maiden name

Talbot Co. Md.

## 15. Birthplace

Williamstown (Bro.)

## 16. Informant

Easton, Md.

## 17.

Burial  
(Burial, cremation, or removal, which?)

Date thereof

July 5, 1945  
(month) (day) (year)

## Cemetery or crematory

Richards

## Location

Easton

## 18. Funeral director

J. Ellis Clark RMC

## Address

Easton, Md.

## 19.

7/5-45  
(Date rec'd by registrar)

19.

45H. H. Heeris  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 3, 1945 at 12:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 2, 1945 to July 3, 1945  
and that I last saw him alive on July 3, 1945

Immediate cause of death

DURATION

Cerebral vascular accident

Due to

arterio sclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please indicate the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. Palmer

M. D. or other

Address

Easton, Md.

Date signed

REC'D  
JUL 13 1945  
FOREAT V. B.  
D

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

## CERTIFICATE OF DEATH

07282

★ Reg. Dist. No. 290

## 1. PLACE OF DEATH:

County Talbot CountyCity or town Easton, Md.  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 5 hrs.

Hospital, institution, or street address where death occurred

Memorial HospitalHow long in hospital or institution? 5 hrs.

## 3. (a) FULL NAME

Mrs Evelyn Knox4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced married6. (b) Name of husband or wife Mr. John KnoxMay 12, 1907 6. (c) If alive, give age 40 years7. Birth date of deceased (mo., day, yr.) May 12, 19078. AGE: Years 38 Months 2 Days 8 If less than one day hrs. min.9. Birthplace Dracommile, Md  
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name David Smith13. Birthplace Maryland14. Maiden name Willie Smith Booker15. Birthplace Md.16. Informant John F. Lusk Jr.Address Trappe17. Burial Date thereof July 23, 1945  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Spring Hill CemeteryLocation Easton Md18. Funeral director W. B. ClarkAddress Easton Md.19. 7/21 19 45 N. H. Neer  
(Date rec'd by registrar) Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County TalbotCity or town Trappe  
(If outside city or town limits, write RURAL and give nearest town)Street No.   
(If rural, give LOCATION)2. (a) If veteran, name war 

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH 7-20 19 45 at 1:45 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 19 19 45 to July 20 19 45and that I last saw him alive on July 20 19 45Immediate cause of death Chronic MyocarditisDURATION 4 hrsDue to Chronic MyocarditisDue to Other conditions 

(Include pregnancy within 3 months of death)

Major findings of operations Date of op. Autopsy results 

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide  Date of Where did injury occur?  (City or town) (County) (State)Injured at home, farm, industry, public place (where?) Means of injury  Injured at work? 23. SIGNATURE John F. Lusk Jr. M.D.Address Easton Md. Date signed 7/23/45



RECEIVED

JUL 26 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Fill correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(159)

07283

## CERTIFICATE OF DEATH

Reg. Dist. No. 290

## 1. PLACE OF DEATH:

County TalbotCity or town Easton Maryland  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Memorial HospitalHow long in hospital or institution? 7 hrs. 2 min

## 3. (a) FULL NAME

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Leinoz

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

July 1, 1945

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

7 hrs.2 min.

9. Birthplace

Easton Ind.  
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Cremation

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

19

45

R. H. Heirus

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

July 1

19

45

21

10

17

M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 1

19

45

to

July 1

19

45

M

and that I last saw him alive on

July 1, 1945

19

45

Immediate cause of death

17 min. - 4 hrs. - 17 min.

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed 7/2/45

RECEIVED

JUL 14 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of age is shown on  
 FILM NO. G 96 JUL 17 1945

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 130

## CERTIFICATE OF DEATH

07284

Reg. Dist. No. 290

### 1. PLACE OF DEATH:

County 1st DISTRICT  
 City or town EASTON, Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 35 years  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Talbot  
 City or town Easton  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 3545  
 (If rural give LOCATION)  
 2. (a) If veteran, name war

### (a) FULL NAME

BERTIE  
NETHAM MURRAY

### 3. (b) Social Security Number

4. Sex female 5. Color or race C 6. (a) Single, married, widowed, or divorced widowed

6. (b) Name of husband or wife William Murray

7. Birth date of deceased (mo., day, yr.) Sept. 10, 1891 8. (c) If alive, give age 45 years

8. AGE: Years 54 Months 53 Days 9 It less than one day 3 hrs. min.

9. Birthplace Easton, Talbot, Md.  
 (Town, county, and state)

10. Usual occupation House Wife

11. Industry or business

12. Name Spencer Taylor

13. Birthplace Virginia

14. Maiden name Willie Taylor

15. Birthplace Talbot County

16. Informant James Cooper

Address Easton, Md.

17. Burial Date thereof July 3/45  
 (Burial, cremation, or other disposal. Which?) (month) (day) (year)

Cemetery or crematory Hammond Chapel Cemetery

Location Easton, Talbot Co., Md.

18. Funeral director Carl W. Hofford

Address Easton, Md.

19. 7/3 19 45 D. H. Dennis  
 (Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH July 2 19 45 at 9 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 4 19 45 to July 2 19 45

and that I last saw him alive on July 2 19 45

Immediate cause of death Acute Pericarditis DURATION 4-5 mo.

Due to Myocarditis

Due to Spontaneous exposure 6 mo.

Other conditions Myocarditis

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Means of injury Injured at work?

23. SIGNATURE Hayward T. Webb M.D. M. D. or other  
 Address Easton, Md. Date signed 7/2/45

CERTIFICATE OF DEATH

RECEIVED  
JUL 11 1945  
BUREAU

101

24

your wife

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 752

## CERTIFICATE OF DEATH

07285

Reg. Dist. No. 290

### 1. PLACE OF DEATH:

County Talbot County  
City or town Easton, Md.  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Memorial Hospital  
long in hospital or institution? 2 1/2 days

### 3. (a) FULL NAME

Dr. Samuel Price

4. Sex

M

5. Color or race

W.

6. (a) Single, married, or divorced

Married

6. (b) Name of husband or wife

Mrs. Eva B. Price

B. (c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.)

June 28 - 1886

8. AGE:

Years

59

Months

Days

27

If less than one day

hrs. min.

9. Birthplace

Elkton Md.  
(Town, county, and state)

10. Usual occupation

Doctor of Medicine

11. Industry or business

FATHER  
MOTHER

12. Name

W. M. Donaldson Price

13. Birthplace

Elkton Md.

14. Maiden name

Katherine Delray Johnson

15. Birthplace

Baltimore Md.

16. Informant

Mrs. Samuel Price

Address

Greensboro Md.

17.

(Burial, cremation, or removal, which?)

Date thereof

7/27/45  
(month) (day) (year)

Cemetery or crematory

Old Wye

Location

Wye Mills Md.

18. Funeral director

Barton Bros

Address

Centerville, Maryland

19.

(Date rec'd by registrar)

8/26/45

45

N. H. Harris

Registrar

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland

County

Queen Anne

City or town

Greensboro  
(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

World War #1 ✓

### 3. (b) Social Security Number

### MEDICAL CERTIFICATION

20. DATE OF DEATH

7-25

19 45 at 3:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 22 to July 25 19 45

and that I last saw him alive on July 25 19 45

Immediate cause of death Heart - Infarction

Heart - Infarction

DURATION

3 days

Due to

Bacterial disease

10 days

Due to

Other conditions Heart - Infarction Pulmonary

phthisis Emphysema Chronic Bronchitis  
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE

M. V. Palmer M.D.

M. D. or other

Address

Easton, Maryland

Date signed 7/25/45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

AUG 4 1945

BUREAU V.S.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 19702

## CERTIFICATE OF DEATH

07286

Reg. Dist. No. 290

## 1. PLACE OF DEATH:

County Talbot  
 City or town Easton  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 11 days  
 Hospital, institution, or street address where death occurred:  
Memorial Hospital  
 How long in hospital or institution? 11 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Talbot  
 City or town St. Michaels  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Howard Scharf

## 3. (b) Social Security Number

none

## 4. Sex

M

## 5. Color or race

White

## 6. (a) Single, married, or divorced

married

## 6. (b) Name of husband or wife

Mrs. Bertha Scharf

## 7. Birth date of deceased (mo., day, yr.)

Jan 15 1875

## 6. (c) If alive, give age \_\_\_\_\_ years

## 8. AGE:

Years	Months	Days	If less than one day
<u>70</u>			

## 9. Birthplace

Baltimore Co. Md  
(Town, county, and state)

## 10. Usual occupation

Decorator

## 11. Industry or business

William J. Scharf

## 12. Name

Baltimore Md

## 13. Birthplace

Sarah Knight

## 14. Maiden name

Baltimore Co. Md

## 15. Birthplace

Bertha A. Scharf

## 16. Informant

St. Michaels, Md

## Address

Cremation

## Date thereof \_\_\_\_\_ (month) (day) (year)

## (Burial, cremation, or removal, which?)

## Cemetery or crematory

Baltimore, Md

## Location

Newnam & Harrison

## 18. Funeral director

St. Michaels, Md.

## Address

7/10

(Date rec'd by registrar)

19 45H.H. Neeris

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 10, 1945 at 12:15 P21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 29, 1945, to July 10, 1945and that I last saw him alive on July 10, 1945

## Immediate cause of death

cardiac embolus

## DURATION

1 hr

## Due to

## Due to

## Other conditions

Prostatectomy 5 days

(Include pregnancy within 3 months of death)

## Major findings of operations

hypertrophied prostate gland Date of op. July 5, 1945

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work?

## 23. SIGNATURE

John F. Schneider, M.D.  
Easton, Md Date signed July 10, 1945

RECEIVED  
JUL 14 1945  
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The entire page is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-2)

## CERTIFICATE OF DEATH



Reg. Dist. No. 07287 290

## 1. PLACE OF DEATH:

County TalbotCity or town Easton  
(If outside city or town limits, write RURAL and give nearest town)How long in above place or death? 29 days

Hospital, institution, or single address where death occurred:

Memorial Hospital, Easton, MdHow long in hospital or institution? 29 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County CarolineCity or town Denton  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION) ✓

2.(a) If veteran, name war \_\_\_\_\_

## 3.(a) FULL NAME

William A. Scottow

## 3.(b) Social Security Number

## 4. Sex

M

## 5. Color or race

W

## 6.(a) Single, married, widowed, or divorced

## 6.(b) Name of husband or wife

Mary A. Scottow

## 7. Birth date of deceased (mo., day, yr.)

Oct. 28, 1873

## 6.(c) If alive, give age \_\_\_\_\_ years

## 8. AGE:

Years

Months

Days

If less than one day

71818

hrs.

min.

## 9. Birthplace

Marydel, Md  
(Town, county, and state)

## 10. Usual occupation

Therman

## 11. Industry or business

FATHER

MOTHER

12. Name

Philemon Scottow

13. Birthplace

Md

14. Maiden name

Rebecca

15. Birthplace

?

## 16. Informant

Address

Mrs. May Scottow  
Denton Md

## 17.

(Burial, cremation, or removal. Which?)

Date hereof

(month) (day) (year)

## Cemetery or crematory

Burial  
Denton Cemetery

## Location

Denton Maryland

## 18. Funeral director

Address

J. Virgil Scottow & Son  
Denton Md

## 19.

(Date rec'd by registrar)

7/1619 45

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 15 19 45, at 10:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 16 19 45 to July 15 19 45and that I last saw him alive on July 15 19 45

## Immediate cause of death

Aemia

## Due to

Carcinoma of descending colon

## Due to

## Other conditions

(Include pregnancy within 3 months of death)

## Major findings of operations

Date of op. \_\_\_\_\_

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

## Where did injury occur?

(City or town)

(County)

(State)

## Injured at home, farm, industry, public place (where?)

## Means of injury

Injured at work?

## 23. SIGNATURE

J. Edgar Baker M.D.

M. D. or other

## Address

Easton

Date signed

7/19/45

RECEIVED  
JUL 26 1945  
BUREAU V. R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

07288

Reg. Dist. No. 591

## 1. PLACE OF DEATH:

County Talbot  
 City or town Royal Oak  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 48 hours

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md. CountyCity or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)Street No. Hopkins apt  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Sarah K. Sheats

## 3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female White Widowed6. (b) Name of husband or wife Tom P. Sheats7. Birth date of deceased (mo., day, yr.) June 11, 1881

6. (c) If alive, give age years

8. AGE: Years Months Days If less than one day  
64 1 13 hrs. min.9. Birthplace Crumpton, Queen Anne's, Maryland  
(Town, county, and state)10. Usual occupation House Wife

11. Industry or business

12. Name Edward R. Walls13. Birthplace Crumpton, Maryland14. Maiden name Emma D. Walls15. Birthplace Crumpton, Maryland16. Informant Mr. Clarence WatersAddress St. Michaels, Maryland17. Burial Date thereof 7/ 27/45  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory CemeteryLocation Druid Ridge, Balto. Maryland18. Funeral director J. Norman MarshallAddress St. Michaels, Maryland19. July 26, 1945 John H. Wawaler  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 24 July 19 45 at 10 P M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from on  
24 July 19 45 toand that I last saw him alive on 24 July 19 45Immediate cause of death Coronary occlusion

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

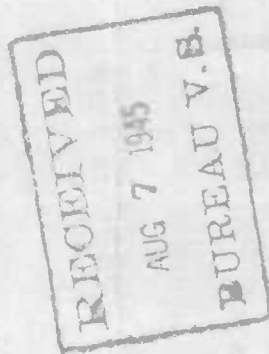
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. L. Perkins M. D. or otherAddress Royal Oak, Md Date signed 7/25

Sarah K. Shook



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 832

## CERTIFICATE OF DEATH

Reg. Dist. No. 290

## 1. PLACE OF DEATH:

County EssexCity or town Essex  
(If outside city or town limits, write RURAL and give nearest town)

How long above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County EssexCity or town Essex  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Sarah Elizabeth Harst

## 3. (b) Social Security Number

4. Sex

F.

5. Color of face

W.

6.(a) Single, married, widowed, or divorced

W.

6.(b) Name of husband or wife

Samuel B. Harst

6.(c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.)

June 17, 1877

8. AGE:

Years

Months

Days

If less than one day

6813

hrs.

min.

9. Birthplace

Essex, Maryland  
(Town, county, and state)

10. Usual occupation

Housekeeper

11. Industry or business

MOTHER

12. Name

John Thammalan

13. Birthplace

MD.

14. Maiden name

Rebecca Thomas

15. Birthplace

MD.

16. Informant

Address

Essex, Md.

17.

(Burial, cremation, or removal; Which?)

Date thereof

July 19, 1945.  
(month) (day) (year)

Cemetery or crematory

Essex, Md.

Location

18. Funeral director

Address

Essex, Md.

19.

(Date rec'd by registrar)

19 45

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 17 19 45, at 5:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb. 19 40 to July 17 19 45  
and that I last saw him alive on July 16 19 45

Immediate cause of death

Cerebral Hemorrhage

DURATION

12 hours

Due to

Cerebral Hemorrhage

Due to

Hypertension

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of Injury

Injured at work?

23. SIGNATURE

J. Tyler Bohn M.D.

M. D. or other

Address

Essex, Md.Date signed 7-17-45



RECEIVED

JUL 20 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 188

## CERTIFICATE OF DEATH

07290

Reg. Dist. No. 290

1. PLACE OF DEATH:  
 County Talbot  
 City or town Easton - outside  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? Life  
 Hospital, institution, or street address where death occurred:  
Carlson Road  
 How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State Maryland County Talbot  
 City or town Easton - Rural  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Carlson Road  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war —

3. (a) FULL NAME Howard B. Todd

3. (b) Social Security Number None

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced — S —  
 6. (b) Name of husband or wife —  
 6. (c) If alive, give age — years  
 7. Birth date of deceased (mo., day, yr.) March 9, 1943  
 8. AGE: Years 2 Months 4 Days 7 It less than one day — hrs. — min.

9. Birthplace Easton, Maryland  
 (Town, county, and state)

10. Usual occupation Spent

11. Industry or business —

12. Name C. Howard Todd

13. Birthplace Caroline County, Maryland

14. Maiden name Mary Ann Spies

15. Birthplace Talbot County, Maryland

16. Informant Mrs. A. Howard Todd

Address Easton, Maryland, R.F.D.

17. Burial Date thereof July 19, 1945

(Burial, cremation, or removal, which?) (month) (day) (year)

Cemetery or crematory Free Chest Cemetery

Location Federalburg, Maryland

18. Funeral director J. J. Trautman & Son

Address Federalburg, Maryland

19. 7/17 19 45 M. D. Harris

(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 16 19 45, at 7 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on — 19 —, at — M.

Immediate cause of death Compound fracture, skull DURATION Immediate

Due to Kicked by horse

Due to —

Other conditions —

(Include pregnancy within 8 months of death)

Major findings of operations — Date of op. —

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work? —

23. SIGNATURE Louis J. Wooten M.D. Dep. Med. Ex.

Address Easton Md M.D. or other —

Date signed 7-16-45

RECEIVED  
JUL 20 1945  
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

## CERTIFICATE OF DEATH

★ Reg. Diat. No. 290

## 1. PLACE OF DEATH:

County Castor  
 City or town Castor  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 54 Yrs.  
 Hospital, institution, or street address where death occurred:  
308 North St.  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Castor  
 City or town Castor  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 308 North St.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

Margaret Harrington Wilson

## 3. (b) Social Security Number

217-03-1354

4. Sex Female 5. Color of race White 6. (a) Single, married, widowed, or divorced Married  
 6. (b) Name of husband or wife Richard B. Wilson  
 6. (c) If alive, give age 49 years  
 7. Birth date of deceased (mo., day, yr.) March 29, 1884  
 8. AGE: Years 61 Months 3 Days 27 If less than one day  
 .....hrs. ....min.

9. Birthplace Laurel, Dela.  
 (Town, county, and state)

10. Usual occupation Housewife & Book keeper

11. Industry or business Coal, Fuel, Oil, Insurance

12. Name Charles P. Harrington

13. Birthplace Del.

14. Maiden name Parake Collins

15. Birthplace Maryland

16. Informant Richard B. Wilson

Address Castor, Md.

17. Burial Date thereof July 28, 1945  
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Spring Hill

Location Castor, Md.

18. Funeral director R. Ellis Clark

Address Castor, Md.

19. 7/27 1945 R. H. Harris  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 26 1945, at 9:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
 1943, to July 26 1945  
 and that I last saw him alive on 7-24 1945

Immediate cause of death Cardiac decompensation DURATION 6 hrs.

Due to Coronary thrombosis 1 yr.

Due to Chronic Myocarditis 2 yrs.

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations  
 ..... Date of op. ....

Autopsy results  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE J. Sylen Bahn M.D.  
 Address Eulton M. D. or other

Date signed 7-26-45

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JUL 30 1945  
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (530)

## CERTIFICATE OF DEATH

Reg. Diat. No. 07292 290

## 1. PLACE OF DEATH:

County Talbot  
 City or town Easton  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 25 days  
 Hospital, institution, or street address where death occurred.  
Memorial Hospital  
 How long in hospital or institution? 25 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Talbot  
 City or town Easton  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Ida Wood

## 3. (b) Social Security Number

4. Sex F. 5. Color or race white 6. (a) Single, married, widowed, or divorced widowed  
 6. (b) Name of husband or wife William T. Wood  
 6. (c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) Mar. 1 1877  
 8. AGE: Years 68 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Ind.  
 (Town, county, and state)  
 10. Usual occupation N.W.  
 11. Industry or business \_\_\_\_\_  
 12. Name George Leonard  
 13. Birthplace Ind.  
 14. Maiden name (husband) Harris  
 15. Birthplace Indiana  
 16. Informant R. Ellis Clark  
 Address Easton Ind.  
 17. Burial Date thereof 7/14/45  
 (Burial, cremation, or removal, which?) (month) (day) (year)  
 Cemetery or crematory Spring Hill  
 Location Easton Ind.  
 18. Funeral director John Clark  
 Address Easton Md.  
 19. 7/12 1945 W.H. Deener  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 11 1945, at 2:55 P.M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from april 1945 to July 11 1945  
 and that I last saw him alive on July 11 1945  
 Immediate cause of death myocardial failure  
 Due to Metastatic Ca. 3 mos.  
Primary focus not determined. Secondary  
 Due to original focus not determined.  
 Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Walter Bahr M.D.  
Easton, Md. M. D. or other \_\_\_\_\_  
 Address \_\_\_\_\_ Date signed 7-14-45

RECEIVED  
JUL 18 1945  
BUREAU V.S.